City of Gulfport

Dental Plan Document

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Article One
Plan Schedule

City of Gulfport Dental Plan: Option 1

Services	Option 1
Deductible per Calendar year (CY) Maximum Family Deductible	$50/person 3 Persons/family
Annual Benefit Maximum (does not apply to Type IV)	$1000
Type I Preventative Dental Services (exams, cleanings, bitewing x-rays, topical fluoride, sealants)	CY Deductible Waived 0% coinsurance*
Type II Basic Dental Services (fillings, extractions, root canals, oral surgery, periodontics, other x-rays)	20% coinsurance after deductible
Type III Major Care (inlays and onlays, most crowns, bridges, dentures)	50% coinsurance after deductible
Type IV Orthodontic Treatment (provided for covered dependent children only)	Not Covered
Orthodontic Lifetime Maximum (Per person; separate and distinct from the Maximum Annual Benefit)	Not Covered

This is a summary of what you will pay for most dental services and treatment. Special Waiting Periods may apply for some services.

*SAS reimburses dental providers at the SAS Dental Fee Schedule, which may be less than the amount charged by your dental provider. The SAS Dental Fee schedule amount will be used to calculate coinsurance amounts. If the dental provider is not a SAS Preferred Dental Provider, the member is responsible for the deductible, coinsurance, and any balance over the SAS reimbursement.

SAS Preferred Dental Providers have agreed to accept the SAS Dental Fee Schedule amount for services covered under your dental plan less the member's deductible and coinsurance, and promise not to balance bill the member. If you have questions concerning this policy, please contact SAS prior to receiving your services.

Note: This document is only a summary of the actual dental benefits being offered. For a detailed description of all your benefits, limitations, and exclusions, see your City of Gulfport Dental Plan Document.

Article One
Plan Schedule

City of Gulfport Dental Plan: Option 2

Services	Option 2
Deductible per Calendar year (CY) Maximum Family Deductible	$50/person 3 Persons/family
Annual Benefit Maximum (does not apply to Type IV)	$2000
Type I Preventative Dental Services (exams, cleanings, bitewing x-rays, topical fluoride, sealants)	CY Deductible Waived 0% coinsurance*
Type II Basic Dental Services (fillings, extractions, root canals, oral surgery, periodontics, other x-rays)	20% coinsurance after deductible
Type III Major Care (inlays and onlays, most crowns, bridges, dentures)	50% coinsurance after deductible
Type IV Orthodontic Treatment (provided for covered dependent children only)	50% coinsurance after deductible
Orthodontic Lifetime Maximum (Per person; separate and distinct from the Maximum Annual Benefit)	$2000

This is a summary of what you will pay for most dental services and treatment. Special Waiting Periods may apply for some services.

*SAS reimburses dental providers at the SAS Dental Fee Schedule, which may be less than the amount charged by your dental provider. The SAS Dental Fee schedule amount will be used to calculate coinsurance amounts. If the dental provider is not a SAS Preferred Dental Provider, the member is responsible for the deductible, coinsurance, and any balance over the SAS reimbursement.

SAS Preferred Dental Providers have agreed to accept the SAS Dental Fee Schedule amount for services covered under your dental plan less the member's deductible and coinsurance, and promise not to balance bill the member. If you have questions concerning this policy, please contact SAS prior to receiving your services.

Note: This document is only a summary of the actual dental benefits being offered. For a detailed description of all your benefits, limitations, and exclusions, see your City of Gulfport Dental Plan Document.

ERISA INFORMATION

Plan Name:

Plan Sponsor (also referred to herein as Plan Administrator, unless otherwise specified):
City of Gulfport
PO Box 1780
Gulfport, MS 39501

Employer Identification Number (EIN): 64-6000413

Plan Number: 501

Plan Administrator: Same as Plan Sponsor

Designated Agent for service of legal process: City of Gulfport Self Funded Health and Dental Plan

or the *Plan Administrator*

Plan Administrator: The *Plan* is administered by the *Plan Administrator* with Union Security Insurance Company, 2323 Grand Boulevard, Kansas City, Missouri 64108, acting as *Dental Claims Administrator*

Type of Administration: Self-administered with third party claims administration.

Plan Contributions: *Employer* and *Employee*, jointly

Trust Fund: N/A

Plan Year: January 1 through December 31

Participating Employers: None

ARTICLE TWO

DEFINITIONS

These terms have the meanings shown here when *italicized.*

Active work means working full-time for an *Employer* at the *Employee's* usual place of business.

Adopting Employer means the *Plan Sponsor*

Benefit year means a calendar year beginning on January 1 of any year and ending on December 31 of that year.

Claimant means an individual who has submitted an application for benefits under the *Plan.*

Contributory means the *Participant* pays part or all of the *Plan* costs and/or benefits through contributions from the *Participant.*

Covered dependent means an *eligible dependent* who is covered under the *Plan.*

Dental Claims Administrator means the person, insurance company or other entity which has accepted appointment by the *Plan Administrator* to provide certain administrative services with respect to the *Plan.*

Dental coverage means the group dental coverage under the *Plan.*

Dental hygienist means an individual who is licensed to practice dental hygiene and acting under the supervision of a *dentist* within the scope of that license in treating the dental condition.

Dentally necessary and dental necessity mean a *treatment* appropriate for the diagnosis and in accordance with accepted dental standards. The *treatment* must be essential for the care of the teeth and supporting tissues.

Dental treatment plan means the *dentist's* report of recommended *treatment* which contains:

(a) a list of the charges and dental procedures required for the *dentally necessary* care;

(b) any supporting X-rays; and

(c) any other appropriate diagnostic materials required.

Dentist means an individual who is licensed to practice dentistry and acting within the scope of that license in treating the dental condition.

Denturist means an individual who is licensed to make dentures and acting within the scope of that license in treating the dental condition.

Doctor means a person acting within the scope of his or her license to practice medicine, prescribe drugs or perform surgery. Also, a person whom we are required to recognize as a *doctor* by the laws or regulations of the governing jurisdiction, or a person who is legally licensed to practice psychiatry, psychology or psychotherapy and whose primary work activities involve the care of patients, is a *doctor.* However, neither you nor an *immediate family member* will be considered a *doctor.*

Eligible class means class of persons eligible to participate under the *Plan.*

Emergency dental care means any *dentally necessary treatment* rendered or received as the direct result of unforeseen events or circumstances which require prompt attention.

Employer means and includes the *Adopting Employer* and any and all *Participating Employers.*

Employee means any person employed by an *Employer* An *Employee* may or may not be a *Participant*

ERISA means the Employee Retirement Income Security Act of 1974, as amended from time to time, and the regulations as amended from time to time and rulings in effect there under.

Family unit means a *Participant* and his *covered dependents.*

Full-Time means working at least 30 hours per week.

Functioning natural tooth means a *natural tooth* which is performing its normal role in the chewing process in the person's upper or lower arch and which is opposed in the person's other arch by another *natural tooth* or prosthetic replacement.

Fund or *Trust Fund* means any *Fund* or *Trust Fund* maintained in connection with the *Plan.*

Immediate family member means a person who is related to the *Participant* in one of the following ways: parent, legally recognized spouse, child or step-child, brother or sister.

Injury means accidental bodily injury It does not mean intentionally self-inflicted injury while sane or insane.

Medicare means a portion of Title XVIII of the United States Social Security Act of 1965, as amended.

Natural tooth means any tooth or part of a tooth that is formed by the natural development of the body Organic portions of the tooth include the crown enamel and dentin, the root cementum and dentin, and the enclosed pulp.

No-Fault motor vehicle coverage means a motor vehicle plan that pays disability or medical benefits without considering who was at fault in any accident that occurs.

Noncontributory means the *Adopting Employer* or *Participating Employer* pays for the entire *Plan* costs and benefits.

Orthodontic treatment means the procedures which provide the corrective movement of teeth through the bone by means of an active appliance to correct a handicapping malocclusion (a malocclusion severely interfering with a person's ability to chew food). Determination of the severity of the malocclusion will be made by the *Dental Claims Administrator*

Other group dental expense coverage means:

(a) any other group plan providing benefits for dental expenses; or

(b) any plan providing dental expense benefits (whether through a dental services organization or other party providing prepaid health or related services) which is arranged through any employer or through direct contact with persons eligible for that plan.

Participant means an eligible *Employee* of an *Employer* who participates in the *Plan.*

Participating Employer means any *Employer* participating in the *Plan* as designated by the *Adopting Employer*

Periodontal maintenance procedures mean recall procedures for patients who have undergone either surgical or non-surgical *treatment* for periodontal disease. The procedures include examination, periodontal evaluation and any further scaling and root planing that is *dentally necessary.*

Plan means the group dental plan established by the *Adopting Employer* that describes benefits for *Participants* and their *covered dependents.*

Plan Administrator shall have the same meaning as provided in *ERISA*.

Plan Sponsor shall have the same meaning as provided in *ERISA*.

Pre-estimate review means review of a *dentist's* statement, including diagnostic X-rays, describing the planned *treatment* and expected charges.

Preferred provider means a *dentist, dental hygienist*, dental office or any dental care provider who is a participant in the *preferred provider option.*

Preferred provider option means a dental care delivery system in which *preferred providers* participate and under which certain dental benefits are provided.

Treatment means any dental consultation, service, supply, or procedure that is needed for the care of the teeth and supporting tissues.

Trust means the *Trust* established under the *Trust Agreement.*

Trust Agreement means the agreement concerning the *Fund* as amended from time to time.

Trustee means the entity acting as *Trustee* under the *Trust Agreement.*

Usual and customary (UC) charge means:

(a) *Usual charge* is the fee regularly charged for a *treatment* to the majority of a *dentist's* patients and accepted as payment in full by an individual dental office. If more than one fee is charged, the fee determined to be the usual fee will not be greater than the lowest fee which is regularly charged or offered to patients.

(b) *Customary charge* is the fee for a given *treatment*, which does not exceed the amount ordinarily charged by the majority of *dentists* in the locality Locality is either a county or such geographically significant area as is necessary to establish a representative base of charges for the type of *treatment* for which the charge is made.

ARTICLE THREE

ELIGIBILITY AND TERMINATION PROVISIONS

Eligible Persons

To be eligible for participation, a person must:

(a) be a member of an *eligible class*; and

(b) complete any Service Requirement shown in the Schedule by continuous service with the *Employer*.

The Present Service Requirement applies to persons in an *eligible class* on the Effective Date of the *Plan*. The Future Service Requirement applies to persons who become members of an *eligible class* after that.

Effective Date for an Eligible Person

(1) Any *noncontributory* participation will take effect on the Entry Date shown in the Schedule.

(2) For any *contributory* participation, a person must apply for participation on an acceptable form, and agree to pay part or all of the cost of participation.

(a) If a person applies before becoming eligible, participation will begin on the Entry Date shown in the Schedule.

(b) If application is made on the date the person becomes eligible, or within 31 days after that, participation will take effect on the date of the application.

(c) If application is made more than 31 days after the day the person becomes eligible or after participation ended because the cost of contribution was not paid, then *dental coverage* will take effect on the date of application. However, for the first 24 months of participation under the *Plan*, the Late Entrant Limitation in the Special Limitations section will apply

(d) If application is made during the *Employer's* annual enrollment period held between November 1 and November 30 of each year, participation will take effect on January 1 of the following year

Exception to Effective Date

If an eligible person is not at *active work* on the day participation would otherwise take effect, participation will not take effect until the person returns to *active work*. If the day participation would normally take effect is not a regular work day for a person, coverage will take effect on that day if the person is able to do his regular job.

When a Participant's Participation Ends

A *Participant's* participation will end on:

(a) the date the *Plan* ends;

(b) the date the *Plan* is changed to terminate participation for a *Participant's eligible class*;

(c) the last day of the month following the date a *Participant* is no longer in an *eligible class*;

(d) the last day of the month following the date a *Participant* stops *active work*;

(e) the date a required contribution was not paid; or

(f) the date a *Participant* becomes covered under an optional dental plan which is:

(i) provided by a Dental Maintenance Organization; and

(ii) sponsored by the *Employer*

Continuance of Participation

If a *Participant* is unable to perform *active work* for a reason shown below, the *Employer* may continue the *Participant's* participation. The continuance cannot be more than the maximum continuance shown below. Continuance will be based on a uniform policy, and not individual selection.

The maximum continuance is the longest applicable period described below:

(a) 12 months after the last day of *active work*, for *injury*, sickness, or pregnancy;

(b) 3 months after the last day of *active work*, for lay-off, leave of absence (other than a family or medical leave of absence described below), or change to part-time; or

(c) the end of the period the *Employer* is required to allow after the last day of *active work*, for a family or medical leave of absence under;

(i) the federal Family and Medical Leave Act; or

(ii) any similar state law.

Reinstatement

If a person re-enters an *Eligible Class* within 12 months after participation ends, the person will not have to complete the Service Requirement again.

ARTICLE FOUR

ELIGIBILITY AND TERMINATION PROVISIONS FOR YOUR DEPENDENTS

Eligible Dependents

A *Participant's eligible dependents* are:

(a) the *Participant's* lawful spouse, and

(b) the *Participant's* unmarried children who are less than age 19, or less than age 24 if a full-time student.

"Children" include any adopted children. A child will be considered adopted on the date of placement in the *Participant's* home. Stepchildren and foster children are also included if they depend on the *Participant* for support and maintenance. "Children" also include any children for whom the *Participant* is the legal guardian, who reside with the *Participant* on a permanent basis and depend on the *Participant* for support and maintenance.

An *eligible dependent* will not include any person who is a member of an *eligible class.* An *eligible dependent* may not be covered by more than 1 *Participant.*

Dependent Effective Date

(1) Any *noncontributory* dependent participation will take effect on the day the dependent becomes an *eligible dependent*, or, if later, on the Entry Date shown on the Schedule.

(2) For any *contributory* dependent participation, the *Participant* must apply for dependent participation on an acceptable form. The *Participant* must also agree to pay all or part of his share of the cost of dependent participation.

(a) If the *Participant* applies before the dependent becomes eligible, dependent participation will take effect on the Entry Date shown in the Schedule.

(b) If the *Participant* applies on the date the dependent becomes eligible, or within 31 days after that, dependent participation will take effect on the date of the application.

(c) If the *Participant* applies more than 31 days after the dependent becomes eligible or after dependent participation ended because the cost of coverage was not paid, dependent participation will take effect on the date of application. However, for the first 24 months after the dependent's participation under the *Plan*, the Late Entrant Limitation in the Special Limitations section will apply

(d) If the *Participant* applies for dependent participation during the *Employer's* annual enrollment period held between November 1 and November 30 of each year, dependent participation will take effect on January 1 of that year

Exception to Dependent Effective Date

Dependent participation will not take effect until *employee* participation coverage under the *Plan* takes effect.

If an *eligible dependent* is in a hospital or similar facility on the day participation would otherwise take effect, it will not take effect until the day after the *eligible dependent* leaves the hospital or similar facility This exception does not apply to a child born while other dependent participation is in effect.

When Dependent Participation Ends

A dependent's participation will end on:

(a) the date the *Plan* ends;

(b) the date the *Plan* is changed to end dependent participation;

(c) the last day of the month following the date that dependent is no longer eligible;

(d) the date the *Employee's* participation for under the *Plan* ends;

(e) the date a required contribution for dependent participation was not paid; or

(f) the date the dependent becomes covered under an optional dental plan which is:

(i) provided by a Dental Maintenance Organization; and

(ii) sponsored by the *Employer*

ARTICLE FIVE

SPECIAL DEPENDENT CONTINUANCE PROVISIONS

As specified below, dependent participation may continue, subject to the provisions that describe when participation ends, and all other terms and conditions of the *Plan*. Contributions are required for any continued participation.

Physically Handicapped or Mentally Retarded Dependent Children

Participation for an *eligible dependent* child will continue beyond the date a child attains an age limit, if, on that date, the child:

(a) is unable to earn a living because of physical handicap or mental retardation; and

(b) is chiefly dependent upon the *Participant* for support and maintenance.

Proof must be received of the above within 31 days after the child attains the age limit and each year after that, beginning two (2) years after the child attains the age limit. There will be no increase in cost of participation for this continuance.

Dependent participation will end when the child is able to earn a living or is no longer dependent on the *Participant* for support and maintenance.

Students

Participation for an *eligible dependent* child will continue beyond the date the child is no longer a student until the earliest of:

(a) the end of the 3rd calendar month following the month in which the child is no longer a student;

(b) the child's 24th birthday; and

(c) the date the child becomes eligible for *other group dental expense coverage*.

ARTICLE SIX

DENTAL PLAN BENEFITS

Benefits Provided

The *Plan* will provide benefits for covered dental expenses identified in the *Plan* when incurred by the *Participant* or a *covered dependent*, while participating under the *Plan*. The *Plan* will pay at the benefit percentage shown in the Schedule after the *Participant* or a *covered dependent* have satisfied any deductible required for the *benefit year*, subject to all the terms and conditions of the *Plan*.

Covered dental expenses will only include *treatment* provided to the *Participant* or a *covered dependent* for which, as outlined in the Covered Dental Expenses section, the date started and the date completed occur while the person is participating in the *Plan*. No payment will be made for a program of dental *treatment* already in progress on the effective date of a person's participation in the *Plan*, except as stated in the Effect of Prior Plan provision. No payment will be made for dental *treatment* completed after the *Participant's* or a *covered dependent's* participation under the *Plan* ends.

Preferred Provider Option

Benefits of the *preferred provider option* will be provided, as shown in the Schedule, for covered expenses incurred by the *Participant* or a *covered dependent* if the *treatment* is provided by a *preferred provider* The *Participant* or a *covered dependent* must be identified as being covered under the *preferred provider option* each time *treatment* is received, to obtain the benefits of the *preferred provider option*. Benefits will be provided under the non-preferred provider option, as shown in the Schedule, for covered dental expenses incurred by the *Participant* or a *covered dependent* if the *treatment* is provided by a dental care provider who is not a participant in the *preferred provider option.*

Deductible

The deductible is the amount shown in the Schedule and will be applied to each class of dental services as indicated in the Schedule. The deductible is the amount of covered dental expenses that the *Participant* and each *covered dependent* must incur in a *benefit year* before benefits will be paid. When covered dental expenses equal to the deductible amount have been incurred and submitted, the deductible will be satisfied. Benefits will not be paid for covered dental expenses applied to the deductible.

If the deductible amount is increased during a *benefit year*, further covered dental expenses must be incurred after the date of increase to satisfy the additional deductible for that *benefit year*

The deductible will apply to the *Participant* and each *covered dependent* separately each *benefit year* except as stated in the Maximum Family Deductible section.

Maximum Family Deductible

The family deductible is shown in the Schedule. It indicates the number of persons in the *Participant's family unit* who must each satisfy an individual deductible in order to satisfy the family deductible. Once that number of persons has satisfied a deductible for a *benefit year*, the deductible will be considered satisfied for each person in the *Participant's family unit* for that *benefit year* Benefits will be paid for covered dental expenses incurred on or after the date the required number of persons has satisfied the deductible amount.

Benefit Year Maximum

The maximum benefit payable during a *benefit year* is shown in the Schedule. This maximum will apply even if coverage for the *Participant* or a *covered dependent* ends and starts again within the same *benefit year* or if the *Participant* or a *covered dependent* have been covered both as an *Participant* and a dependent.

Maximum Benefit for Temporomandibular Joint (TMJ) Treatment

The maximum benefit payable, while covered under the *Plan*, for *treatment* of temporomandibular joint dysfunction is shown in the Schedule. Any benefits applied to this maximum will also be applied to the Benefit Year Maximum for the *benefit year* in which the expense is incurred.

Termination of a Preferred Provider's Participation under the Preferred Provider Option

If the *Participant* or a *covered dependent* incur covered dental expenses with a *preferred provider* after the provider's participation in the *preferred provider option* has ended, benefits will not be payable for the *Participant* or the *covered dependent* under the *preferred provider option*. However, benefits will be provided under the non-preferred provider option shown in the Schedule.

Termination of the Plan's Participation under the Preferred Provider Option

If the *Participant* or a *covered dependent* incur covered dental expenses with a *preferred provider* after the *Plan's* participation in the *preferred provider option* has ended, for any reason, benefits will not be payable for the *Participant* or the *covered dependent* under the *preferred provider option*. However benefits will be provided under the non-preferred provider option shown in the Schedule.

Covered Dental Expenses

Covered dental expenses include only the lesser of the amount agreed upon by the *preferred provider* under the *preferred provider option,* the *dentist's* actual charge, or the *usual or customary charge* for expenses incurred by you or a *covered dependent*. The *treatment* must be:

(a) performed by or under the direction of a *dentist*, or performed by a *dental hygienist* or *denturist*;

(b) *dentally necessary*; and

(c) started and completed while the *Participant* or the *Participant's covered dependent* are participating under the *Plan*, except as otherwise provided in the Effect of Prior Plan.

Dental *treatment* is considered to be started as follows:

(a) for a full or partial denture, the date the first impression is taken;

(b) for a fixed bridge, crown, inlay and onlay, the date the teeth are first prepared;

(c) for root canal therapy, on the date the pulp chamber is first opened;

(d) for periodontal surgery, the date the surgery is performed; and

(e) for all other *treatment*, the date *treatment* is rendered.

Dental *treatment* is considered to be completed as follows:

(a) for a full or partial denture, the date a final completed appliance is first inserted in the mouth;

(b) for a fixed bridge, crown, inlay and onlay, the date an appliance is cemented in place; and

(c) for root canal therapy, the date a canal is permanently filled.

(See Class IV· Orthodontic Dental Services for start and completion dates for *orthodontic treatment*.)

Expenses submitted must identify the *treatment* performed in terms of the American Dental Association Uniform

Code on Dental Procedures and Nomenclature or by narrative description. The Plan reserves the right to request X-rays, narratives and other diagnostic information, as seen fit, to determine benefits.

Benefits will only be paid for covered dental expenses incurred for *treatment* which, was determined to have a reasonably favorable prognosis for the patient.

A temporary *treatment* will be considered to be an integral part of the final *treatment*. The sum of the fees for temporary and final *treatment* will be used to determine whether the charges are *usual and customary*

The following is a complete list of covered dental expenses. Benefits will not be paid for expenses incurred for any service not listed in the *Plan*.

CLASS I: Preventive Dental Services

(1) periodic or comprehensive oral evaluation, limited to 1 time in any 6-month period;

(2) intraoral complete series X-rays, including bitewings and 10 to 14 periapical X-rays, or panoramic film, limited to 1 time in any 60-month period;

(3) bitewing X-rays (2 or 4 films), limited to 1 time in any 12-month period;

(4) dental prophylaxis, limited to 1 time in any 6-month period;

(5) topical fluoride *treatment*, limited to:

  (a) 1 time in any 6-month period; and

  (b) *covered dependent* children less than age 14;

(6) sealants, limited to:

  (a) 1 time per tooth in any 36-month period;

  (b) applications made to permanent molar teeth; and

  (c) *covered dependent* children less than age 14;

(7) space maintainers, including all adjustments made within 6 months of installation, limited to *covered dependent* children less than age 19.

CLASS II: Basic Dental Services - Non-Restorative

(1) limited oral evaluation-problem focused, considered for payment as a separate benefit only if no other *treatment* (except X-rays) is rendered during the visit;

(2) intraoral periapical X-rays;

(3) intraoral occlusal X-rays, limited to 1 film in any 6-month period;

(4) extraoral X-rays, limited to 1 film in any 6-month period;

(5) other X-rays (except films related to orthodontic procedures or temporomandibular joint dysfunction);

(6) histopathological examination;

(7) stainless steel crowns, limited to:

(a) 1 time in any 36-month period;

(b) teeth not restorable by an amalgam or composite filling; and

(c) *covered dependent* children less than age 19;

(8) pulpotomy;

(9) root canal therapy, including all pre-operative, operative and post-operative X-rays, bacteriologic cultures, diagnostic tests, local anesthesia and routine follow-up care, limited to 1 time on the same tooth in any 24-month period;

(10) apicoectomy/periradicular surgery (anterior bicuspid, molar, each additional root), including all pre-operative, operative and post-operative X-rays, bacteriologic cultures, diagnostic tests, local anesthesia and routine follow-up care;

(11) retrograde filling--per root;

(12) root amputation--per root;

(13) hemisection, including any root removal and an allowance for local anesthesia and routine post-operative care, does not include a benefit for root canal therapy;

(14) periodontal scaling and root planing (per quadrant), limited to 1 time per quadrant of the mouth in any 24-month period;

(15) *periodontal maintenance procedure* (following active treatment), limited to 1 dental prophylaxis or 1 *periodontal maintenance procedure* in any 6-month period;

(16) periodontal related services as listed below, limited to 1 time per quadrant of the mouth in any 36-month period with charges combined for each of these services performed in the same quadrant within the same 36-month period:

(a) gingivectomy;

(b) osseous surgery;

(17) osseous grafts;

(18) pedicle grafts;

(19) tissue grafts;

(20) periodontal appliances, limited to 1 appliance in any 12-month period;

(21) simple extraction;

(22) oral surgery services as listed below, including an allowance for local anesthesia and routine post-operative care;

(a) surgical extractions (including extraction of wisdom teeth);

(b) alveoloplasty;

(c) vestibuloplasty;

(d) removal of exostosis--maxilla or mandible;

(e) frenulectomy (frenectomy or frenotomy);

(f) excision of hyperplastic tissue--per arch;

(23) tooth re-implantation and/or stabilization of accidentally evulsed or displaced tooth and/or alveolus;

(24) extraction, erupted tooth or exposed root (elevation and/or forceps removal);

(25) biopsy;

(26) incision and drainage;

(27) palliative (emergency) treatment of dental pain, considered for payment as a separate benefit only if no other *treatment* (except X-rays) is rendered during the visit;

(28) general anesthesia and intravenous sedation, limited as follows:

(a) considered for payment as a separate benefit only when determined medically necessary and hen administered in the *dentist's* office or outpatient surgical center in conjunction with complex oral surgical services which are covered under the *Plan*;

(b) benefits for general anesthesia will be based on the benefit allowed for the corresponding intravenous sedation;

(29) consultation, including specialist consultations, limited as follows:

(a) considered for payment only if billed by a *dentist* who is not providing operative *treatment*;

(b) benefits will not be considered for payment if the purpose of the consultation is to describe the *dental treatment plan*;

(30) therapeutic drug injections.

CLASS II: Basic Dental Services - Restorative

(1) amalgam restorations, limited as follows:

(a) multiple restorations on one surface will be considered a single filling;

(b) benefits for the replacement of an existing amalgam restoration will only be considered for payment if at least:

(i) 12 months have passed since the existing amalgam restoration was placed if the *Participant* or *covered dependent* is less than age 19; or

(ii) 36 months have passed since the existing amalgam restoration was placed if the *Participant* or *covered dependent* is age 19 or older;

(c) mesial, lingual, buccal (MLB) and distal, lingual, buccal (DLB) restorations will be considered single surface restorations;

(2) silicate restorations;

(3) plastic restorations;

(4) composite restorations, limited as follows:

(a) mesial-lingual, distal-lingual, mesial-buccal, and distal-buccal restorations on anterior teeth will be considered single surface restorations;

(b) acid etch is not covered as a separate procedure;

(c) benefits for the replacement of an existing composite restoration will only be considered for payment if at least:

(i) 12 months have passed since the existing composite restoration was placed if the *Participant* or *covered dependent* is less than age 19; or

(ii) 36 months have passed since the existing composite restoration was placed if the *Participant* or *covered dependent* is age 19 or older;

(d) benefits for composite resin restorations on posterior teeth will be based on the benefit for the corresponding amalgam restoration;

(5) pin retention restorations, covered only in conjunction with an amalgam or composite restoration, pins limited to 1 time per tooth.

CLASS III: Major Dental Services

All benefits for the services listed below include an allowance for all temporary restorations and appliances, and 1 year follow-up care.

(1) inlays and onlays;

(a) covered only when the tooth cannot be restored by an amalgam or composite filling;

(b) covered only if more than 5 years have elapsed since last placement; and

(c) limited to persons over age 16;

(2) porcelain restorations on anterior teeth;

(3) crowns;

(a) covered only when the tooth cannot be restored by an amalgam or composite filling;

(b) covered only if more than 5 years have elapsed since last placement; and

(c) limited to persons over age 16;

(4) recementing inlays;

(5) recementing crowns;

(6) crown build-up, including pins and prefabricated posts;

(7) post and core, covered only for endodontically treated teeth requiring crowns;

(8) full dentures, limited as follows:

(a) limited to 1 time per arch unless:

(i) 5 years have elapsed since last replacement; and

(ii) the denture cannot be made serviceable;

(b) additional benefits will not be paid for personalized dentures or overdentures or associated *treatment*;

(c) any denture will not be paid until it is accepted by the patient;

(9) partial dentures, including any clasps and rests and all teeth, limited as follows:

(a) limited to 1 partial denture per arch unless:

(i) 5 years have elapsed since last replacement (see the Denture or Bridge Replacement/Addition provision for exceptions); and

(ii) the partial denture cannot be made serviceable;

(b) there are no benefits for precision or semi-precision attachments;

(10) denture adjustments, limited to:

(a) 1 time in any 12-month period; and

(b) adjustments made more than 12 months after the insertion of the denture;

(11) repairs to full or partial dentures, bridges, crowns and inlays, limited to repairs or adjustments performed more than 12 months after the initial insertion;

(12) relining or rebasing dentures, limited to:

(a) 1 time in any 36-month period; and

(b) relining or rebasing done more than 12 months after the insertion of the denture;

(13) tissue conditioning, limited to repairs or adjustment performed more than 12 months after the initial insertion of the denture;

(14) fixed bridges (including Maryland bridges), limited as follows:

(a) limited to persons over age 16;

(b) benefits for the replacement of an existing fixed bridge are payable only if the existing bridge:

(i) is more than 5 years old (see the Denture or Bridge Replacement/Addition provision for exceptions); and

(ii) cannot be made serviceable;

(c) a fixed bridge replacing the extracted portion of a hemisected tooth is not covered;

(d) the date the bridge is cemented in the mouth will used in determining the amount that will be applied to the *benefit year* Maximum shown in the Plan Schedule;

(15) recementing bridges, limited to repairs or adjustment performed more than 12 months after the initial insertion;

(16) non-surgical Temporomandibular Joint (TMJ) *treatment* for myofascial pain syndrome, muscular, neural, or skeletal disorder, dysfunction or disease of the Temporomandibular Joint including *treatment* of the chewing muscles to relieve pain or muscle spasm, TMJ X-rays, and occlusal adjustments, limited as follows:

(a) coverage does not include an allowance for appliances for tooth movement or guidance, electronic diagnostic modalities, occlusal analysis, or muscle testing;

(b) the Overall Maximum Benefit for Temporomandibular Joint (TMJ) Treatment and the Benefit Year Maximum shown in the Schedule will apply

CLASS IV: Orthodontic Dental Services

(1) cephalometric X-rays;

(2) diagnostic casts, limited to casts made for orthodontic purposes;

(3) surgical exposure of an impacted tooth, limited to services performed for orthodontic purposes;

(4) orthodontic appliances for tooth guidance; and

(5) fixed or removable appliances to correct harmful habits.

Benefits for *orthodontic treatment* will be provided to covered dependent children only

Benefits for *orthodontic treatment* are not payable for expenses incurred for retention of orthodontic relationships. Benefits for *orthodontic treatment* are payable only for active *orthodontic treatment* for the services listed above.

Benefits will be paid for the orthodontic services listed above when the date started for the orthodontic service occurs while the person is covered under this *Plan*. No payment will be made for *orthodontic treatment* if the appliances or bands are inserted prior to becoming covered. *Orthodontic treatment* will be considered to be started on the date the bands or appliances are inserted. Any other *orthodontic treatment* that can be completed on the same day it is rendered is considered to be started and completed on the date the *orthodontic treatment* is rendered.

The benefit percentage amount shown in the Schedule will be paid after any required deductible for orthodontic services has been satisfied for the *benefit year* The maximum benefit payable to each *covered dependent* child, while covered under the *Plan*, for orthodontic services is shown in the Schedule. The maximum benefit will apply even if coverage is interrupted. Benefits paid for orthodontic services will not be applied to the Benefit Year Maximum shown in the Schedule.

A payment will be made for covered orthodontic services related to the initial *orthodontic treatment* which consists of diagnosis, evaluation, pre-care and insertion of bands or appliances. After the payment for the initial *orthodontic treatment*, benefits for covered orthodontic services will be paid in equal quarterly installments over the course of the remaining *orthodontic treatment*. The benefit payment schedule for the initial *orthodontic treatment* and quarterly installments will be determined as follows:

(1) The lesser of the *usual or customary charge* and the orthodontist's fee will be determined and

multiplied by the benefit percentage shown in the Schedule.

(2) The lesser of the amount from number 1 or the Overall Maximum Benefit for orthodontic services shown in the Schedule will be the maximum benefit payable. An initial amount of 25% of the maximum benefit payable will be paid for the initial *orthodontic treatment*. This amount will be payable as of the date appliances or bands are inserted.

(3) The remaining 75% of the maximum benefit payable will be divided by the number of quarters that *orthodontic treatment* will continue to determine the amount which will be payable for each subsequent quarter of *orthodontic treatment*. The subsequent quarterly payments will made only if the *covered dependent* child remains covered under the *Plan* and provides proof that *orthodontic treatment* continues. If *orthodontic treatment* continues after the maximum benefit payable has been paid, no further benefits will be paid.

Pre-estimate

If the charge for any *treatment* is expected to exceed $300, it is recommended that a *dental treatment plan* be submitted for review before *treatment* begins. An estimate of the benefits payable will be sent to the *Participant* and the *dentist*.

In addition to a *dental treatment plan*, before *orthodontic treatment* begins, the *Dental Claims Administrator* may request any of the following information to help determine benefits payable for orthodontic services:

(1) full mouth dental X-rays;

(2) cephalometric X-rays and analysis;

(3) study models; and

(4) a statement specifying:

  (a) degree of overjet, overbite, crowding and open bite;

  (b) whether teeth are impacted, in crossbite, or congenitally missing;

  (c) length of *orthodontic treatment*; and

  (d) total *orthodontic treatment* charge.

In estimating the amount of benefits payable, the *Plan* will consider whether or not an alternate *treatment* may accomplish a professionally satisfactory result. If the *Participant* or a *covered dependent* and the *dentist* agree to a more expensive *treatment* than that pre-estimated under the *Plan*, the excess amount will not be paid.

The pre-estimate is not an agreement for payment of the dental expenses. The pre-estimate process lets the *Participant* or a *covered dependent* know in advance approximately what portion of the expenses will be considered covered dental expenses under the *Plan*.

Alternate Treatment

If an alternate *treatment* can be performed to correct a dental condition, the maximum covered dental expense consider for payment under the *Plan* will be the most economical *treatment* which will, as determined by the *Dental Claims Administrator*, produce a professionally satisfactory result.

Special Limitations

Waiting Period for Timely Applicants

If an *employee* applies for *dental coverage* before or within 31 days of the date the *employee* or a dependent become eligible, the *employee* and any eligible dependents are timely applicants. Under the Waiting Period for Timely Applicants, benefits will not be paid for the following services until the *Participant* and *covered dependents* have been continuously covered under the *Plan* for the stated period of time:

Class III and Class IV Dental Services - 6 months

If *treatment* for a service listed above is started during the Waiting Period, only the portion of the *treatment* rendered after the end of the Waiting Period will be considered a covered dental expense.

Late Entrant Limitation

If an *employee* applies for *dental coverage* more than 31 days after the *employee* or any eligible dependents first become eligible or after participation in the *Plan* ended because a required contribution was not paid, the *employee* and any eligible dependents are late entrants. The benefits for the first 24 months of coverage for late entrants will be limited as follows:

(a) Until the late entrant has been covered under the *Plan* for 6 months in a row, benefits will include coverage for only Class I Dental Services;

(b) Until the late entrant has been covered under the *Plan* for 12 months in a row, benefits for the second 6 months will then include coverage for only Class I and Class II Restorative Dental Services; and

(c) Until the late entrant has been covered under the *Plan* for 24 months in a row, benefits for the second 12 months will then include coverage for only Class I and Class II Non-Restorative and Restorative Dental Services.

If *treatment* for a service limited under this provision is started during the Late Entrant Limitation period, only the portion of the *treatment* rendered after the end of the Late Entrant Limitation period will be considered a covered dental expense.

Denture or Bridge Replacement/Addition

As stated in the Covered Dental Expenses section, benefits will not be paid for the replacement of a full denture, partial denture, fixed bridge or for teeth added to a partial denture unless:

(a) 5 years have elapsed since last replacement of the denture or bridge; and

(b) the denture or bridge cannot be made serviceable;

(c) the *Participant* or *covered dependent* has participated in the *Plan* for 24 consecutive months;

However, the following exceptions will apply:

(a) benefits for the replacement of an existing partial denture that is less than 5 years old will be payable if there is a *dentally necessary* extraction of an additional *functioning natural tooth*;

(b) benefits for the replacement of an existing fixed bridge that is less than 5 years old will be payable if:

(i) there is a *dentally necessary* extraction of an additional *functioning natural tooth*; and

(ii) the extracted tooth was not an abutment to an existing bridge.

General Exclusions

Benefits will not be paid for expenses incurred for any of the following:

(1) *treatment* which:

(a) is not included in the list of covered dental expenses;

(b) is not *dentally necessary*;

(c) is experimental in nature; or

(d) does not have uniform professional endorsement;

(2) appliances, inlays, cast restorations, crowns, or other laboratory prepared restorations used primarily for the purpose of splinting;

(3) any *treatment* or appliance, the sole or primary purpose of which relates to:

(a) the change or maintenance of vertical dimension;

(b) the alteration or restoration of occlusion except for occlusal adjustment in conjunction with periodontal surgery or temporomandibular joint disorder;

(c) bite registration; or

(d) bite analysis;

(4) replacement of a lost or stolen appliance or prosthesis;

(5) educational procedures, including but not limited to oral hygiene, plaque control or dietary instructions;

(6) completion of claim forms or missed dental appointments;

(7) personal supplies or equipment, including but not limited to water piks, toothbrushes, or floss holders;

(8) *treatment* for a jaw fracture;

(9) *treatment* provided by a *dentist, dental hygienist, denturist* or *doctor* who is:

(a) an *immediate family member* or a person who ordinarily resides with the *Participant* or a *covered dependent;*

(b) an *employee* of the *Employer*; or

(c) an *Employer*;

(10) hospital or facility charges for room, supplies or emergency room expenses; or routine chest X-

rays and medical exams prior to oral surgery;

(11) *treatment* performed outside the United States, except for *emergency dental care*. The maximum benefit payable to any person during a *benefit year* for covered dental expenses related to *emergency dental care* performed outside the United States is $100;

(12) *treatment* resulting from or in the course of the *Participant's* or a *covered dependent's* regular occupation for pay or profit for which the *Participant* or *covered dependent* are entitled to benefits under any Workers' Compensation Law, Employer's Liability Law or similar law The *Participant* must promptly claim and notify the *Plan* of all such benefits;

(13) *treatment* for which these conditions exist:

(a) charges are payable or reimbursable by or through a plan or program of any governmental agency, except if the charge is related to a non-military service disability and *treatment* is provided by a governmental agency of the United States. However, any state or local medical assistance (Medicaid) agency for covered dental expenses will always be reimbursed;

(b) charges are not imposed against the person or for which the person is not liable;

(c) charges are reimbursable by *Medicare* Part A & Part B.* If a person at any time was entitled to enroll in the *Medicare* program (including Part B) but did not do so, his benefits under the *Plan* will be reduced by any amount that would have been reimbursed by *Medicare*, where permitted by law;

* However, for persons covered under *Employers* who employed 20 or more *employees* during the previous business year, this exclusion will not apply to an actively working *Participant* and/or his spouse who is age 65 or older if the *Participant* elects to participate under the *Plan* instead of obtaining coverage under *Medicare.*

(14) *treatment* provided primarily for cosmetic purposes;

(15) *treatment* which may not reasonably be expected to successfully correct the person's dental condition for a period of at least 3 years, as determined by the *Dental Claims Administrator*;

(16) crowns, inlays, cast restorations, or other laboratory prepared restorations on teeth which may be restored with an amalgam or composite resin filling;

Effect of Prior Plan

This provision applies only to *Participants* and their *covered dependents* who elect to participate on the effective date of the *Plan*, unless otherwise specified below.

Definitions

Prior plan means the *Employer's* plan of group dental insurance that was replaced by the *Plan*.

Continuity of Coverage for Participants

The *Plan* will provide continuity of coverage if the *Participant* was covered under the *prior plan* on the day before coverage was replaced by the *Plan*.

If the *Participant*

(a) is at *active work* on the Effective Date of the *Plan* and

(b) applies for coverage before or within 31 days of the Effective Date of the *Plan*,

the *Participant* will be covered under the *Plan.*

If the *Participant* is not at *active work* on the Effective Date of the *Plan*, the *Participant* will be covered by the *Plan* and will be provided the benefits of the *Plan* until the earliest of:

(a) the end of any period of continuance of the *prior plan*;

(b) the date a required contribution, if any, was not paid; or

(c) the date coverage ends, according to the provisions of the *Plan*.

Continuity of Coverage for Eligible Dependents

We will provide continuity of coverage for the *Participant's eligible dependents*, if any, who were covered under the *prior plan* on the day before coverage was replaced by the *Plan.*

If

(a) the dependent is not in a hospital or similar facility on the Effective Date of the *Plan*, and

(b) the *Participant* applies for dependent coverage before or within 31 days of the Effective Date of the *Plan*,

the dependent will be covered under the *Plan*.

If the dependent is in a hospital or similar facility on the Effective Date of the *Plan*, the dependent will be covered by the *Plan* and will be provided the benefits of the *Plan* until the earliest of:

(a) the end of any period of continuance of the *prior plan*; or

(b) the date a required contribution, if any, was not paid; or

(c) the date coverage ends, according to the provisions of the *Plan*.

Prior Extractions

If *treatment* is *dentally necessary* due to an extraction which occurred before the effective date of this *Plan* but while the *Participant* or *covered dependent* were covered under the *prior plan* and *treatment* would have been covered under the *Employer's prior plan*, the Coverage for Treatment in Progress provision will be applied as stated below and expenses will be considered as follows:

(a) the replacement of the extracted tooth must take place within 12 months of extraction; and

(b) expenses must be covered dental expenses under this *Plan* and the *prior plan*.

Waiting Periods and Late Entrant Limitations

If the *Participant* or a *covered dependent*:

(a) was covered under the *prior plan* on the day before the *prior plan* was replaced by this *Plan*;

(b) are eligible on the effective date of this *Plan* for *dental coverage*;

(c) and the *employee* elects participation under this *Plan* before or within 31 days of the effective date of this *Plan*,

then any Waiting Period for Timely Applicants will be waived for that person for any Class of dental services covered under the *prior plan* and this *Plan*.

If the *Participant* or a *covered dependent*:

(a) was eligible but not covered under the *prior plan* on the day before the *prior plan* was replaced by this *Plan*;

(b) is eligible to participate on the effective date of this *Plan*; and

(c) the *employee* elects participation under this *Plan* before or within 31 days of the effective date of this *Plan*,

then the *Participant* and any *covered dependents* will be subject to the Late Entrant Limitation in the Special Limitations section.

Coverage for Treatment in Progress

If the *Participant* or a *covered dependent* was covered under the *prior plan* on the day before the *prior plan* was replaced by this *Plan*, benefits will be paid for any program of dental *treatment* already in progress on the effective date of this *Plan* as stated below. However, the expenses must be covered dental expenses under this *Plan* and the *prior plan*.

Extension of Benefits under Prior Plan

This *Plan* will not pay benefits for *treatment* if:

(a) the *prior plan* has an extension of benefits provision;

(b) the *treatment* expenses were incurred under the *prior plan*; and

(c) the *treatment* was completed during the *prior plan's* extension of benefits.

No Extension of Benefits under Prior Plan

This *Plan* will pro-rate benefits according to the percentage of *treatment* performed while insured under the *prior plan* if:

(a) the *prior plan* has no extension of benefits when that plan terminates;

(b) the *treatment* expenses were incurred under the *prior plan*; and

(c) the *treatment* was completed while participating under this *Plan*.

Treatment Not Completed during Extension of Benefits

This *Plan* will pro-rate benefits according to the percentage of *treatment* performed while insured under the *prior plan* and during the extension if:

(a) the *prior plan* has an extension of benefits;

(b) the *treatment* expenses were incurred under the *prior plan*; and

(b) the *treatment* was not completed during the *prior plan*'s extension of benefits.

This *Plan* will consider only the percentage of *treatment* completed beyond the extension period to determine any benefits payable under this *Plan*.

ARTICLE SEVEN

COORDINATION OF BENEFITS

Applicability

All of the benefits provided under this *Plan* are subject to *this provision.*

Definitions

Allowable expense means any *dentally necessary, usual and customary charge*, at least a portion of which is covered under 1 or more of the *programs* which cover the person:

(a) for whom claim is made, and

(b) on whose account payment is legally required.

When a *program* provides benefits in the form of services rather than cash payments, the reasonable cash value of each service rendered will be both an *allowable expense* and a benefit paid.

When benefits are reduced because the person does not comply with the provisions of a *program*, the amount of the reduction will not be considered an *allowable expense*. However, any services rendered by a non-HMO/DMO provider for which the HMO/DMO denies payment will be considered an *allowable expense*.

Claim period means a calendar year. A *claim period* will not start before a person's effective date of insurance under this *Plan* nor extend beyond the last day the person is covered under this *Plan*.

Medicaid means the Title XIX of the Social Security Act of 1965 as amended.

Program means any program which provides benefits or services for medical or dental care or treatment through:

(a) group, blanket, or franchise insurance coverage;

(b) group hospital, medical, or dental service prepayment coverage, group or individual practice or other group prepayment coverage, or group-type coverage through Health Maintenance Organizations (HMOs) or Dental Maintenance Organizations (DMOs);

(c) a labor-management trusteed plan, union welfare plan, employer or employee organization plan or any other arrangement of benefits, not available to the general public, which is based on membership in a group;

(d) coverage under government programs or coverage required or provided by any statute, except *Medicaid*. Benefits and services provided by Part A and Part B of *Medicare* are included. If the *Participant* or a *covered dependent* are eligible for, but not covered under both Part A and Part B of *Medicare* for any reason, the benefits or services that would have been payable if the *Participant* or the *covered dependent* had been covered, will be included, unless prohibited by state law or regulation; or

(e) *no-fault motor vehicle coverage* or a Motor Vehicle Financial Responsibility Act, unless prohibited by state law or regulation.

Program does not include any of the following.

(a) *school accident coverage*;

(b) the first $30 per day of benefits under a group or group-type hospital indemnity benefit, written on

a non-expense incurred basis;

(c) *Medicaid*; and does not include a law or *program* when, by law, its benefits are in excess of those of any private or other non-governmental plan; or

(d) *no-fault motor vehicle coverage* or a Motor Vehicle Financial Responsibility Act, which, according to its rules, determines its benefits after the benefits of this *Plan* have been determined, or any optional *no-fault motor vehicle coverage.*

The term *program* will be construed separately for each policy, contract, or other arrangement for benefits or services. It will also be construed separately for:

(a) that part of any policy, contract, or other arrangement which has the right to consider the benefits or services of other *programs* in determining its benefits; and

(b) that part which does not.

Primary program means a *program* whose benefits for health care coverage must be determined without considering the existence of any other *program.* A *program* is *primary* if:

(a) the *program* has no order of benefit determination rules, or it has rules which differ from *this provision*; or

(b) under the order of benefit determination rules, this *Plan* determines its benefits first.

School accident coverage means coverage for elementary, high school, or college students for accidents only, including athletic injuries, either on a 24-hour basis or on a "to and from school" basis.

Secondary program is not a *primary program*, and may consider the benefits of the *primary program* and the benefits of any other *program* which, under the rules of *this provision*, has its benefits determined before those of that *secondary program.*

This provision means the provision for coordination between the benefits of this *Plan* and other *programs.*

Other definitions which may apply to this Coordination of Benefits section appear in the Definitions section of the *Plan.*

Order of Benefit Determination

The rules to establish the order of benefit determination for each *program* are as follows:

(1) A *program* which covers the *claimant* as an employee, member or subscriber (that is, other than as a dependent) will determine its benefits before a *program* which covers the *claimant* as a dependent. However, if the *claimant* is also a *Medicare* beneficiary, and as the result of the rule established by Title XVIII of the Social Security Act and implementing regulations,

(a) the *program* covering the *claimant* as a dependent will determine its benefits before *Medicare*; and

(b) *Medicare* will determine its benefits before the *program* covering the *claimant* as other than a dependent (e.g. a retired employee). Then the *program* covering the *claimant* as a dependent will determine its benefits before the *program* covering the *claimant* as other than a dependent.

(2) In the event that the *claimant* is a dependent child whose parents are not divorced or separated, benefits for the child are determined in this order:

(a) first, the *program* which covers the *claimant* as a dependent child of the parent whose birthdates occurs earlier in a calendar year; and

(b) second, the *program* which covers the *claimant* as a dependent child of the parent whose birthdates occurs later in the calendar year.

If both parents have the same birthdates, benefits for the child are determined in this order:

(a) first the *program* which covered the parent longer; and

(b) second, the *program* which covered the other parent for a shorter period of time.

(3) If the other *program* does not contain this exact rule regarding dependents, then this rule will not apply, and the rules set forth in the other *program* will determine the order of benefits.

(4) In the event that the *claimant* is a dependent child whose parents are divorced or separated, benefits for the child are determined in this order:

(a) When the parent with custody of the child has not remarried,

(i) first, the *program* which covers the child as a dependent of the parent with custody; and

(ii) second, the *program* which covers the child as a dependent of the parent without custody; or

(b) When the parent with custody of the child has remarried,

(i) first, the *program* which covers the child as a dependent of the parent with custody; and

(ii) second, the *program* which covers that child as a dependent of the stepparent; and

(iii) finally, the *program* which covers that child as a dependent of the parent without custody; or

(c) When the parents have joint custody of the child and the court does not decree which parent is responsible for the health care expenses of the child, then benefits for the child will be determined according to the birthdate rule described above.

(d) If the specific terms of a court decree that one parent is responsible for the health care expenses of the child, and the entity obligated to pay or provide the benefits of the *program* of that parent has actual knowledge of these terms, then

(i) first, the *program* of parent with financial responsibility; and

(ii) second, the *program* of the other parent.

This does not apply to any *claim period* during which any benefits are actually paid or provided before the entity has that actual knowledge.

(e) If the specific terms of a court decree state that both parents are responsible for the health care expenses of the child but gives physical custody of the child to a particular parent, then benefits for the child will be determined according to the birthday rule

described above.

(5) A *program* which covers the *claimant* as a laid-off or retired employee, or as a dependent of that person, will determine its benefits after a *program* covering such *claimant* as an employee, other than a laid-off or retired employee, or as a dependent of that person.

If a *program* does not have a provision regarding laid-off or retired employees, which results in each *program* determining its benefits after the other, then this rule will not apply

(6) When the *claimant* whose coverage is provided under a federal or state continuation law is also covered under another *program*, benefits are determined in this order:

(a) first, the *program* which covers the *claimant* as an employee; and

(b) second, the *program* which covers the *claimant* under a continuation law.

If the other *program* does not have a provision regarding coverage provided under continuation laws, then this rule will not apply

(7) When none the rules described above establish an Order of Benefit Determination, a *program* which has covered the *claimant* longer will determine its benefits before a *program* which has covered that *claimant* for a shorter period of time.

Effect on Benefits

A *primary program's* benefits are not reduced because of the existence of another *program*.

When there are more than two *programs*, this *Plan* may be a *primary program* to one or more other *programs*, and may be a *secondary program* to a different *program(s)*.

When this *Plan* is a *secondary program*, benefits payable under this *Plan* will be reduced so that when they are added to the benefits payable under all other *programs*, they will not exceed the total *allowable expenses* incurred by the *Participant* or a *covered dependent* during the *claim period*. Benefits payable under any other *program* include the benefits that would have been payable had the claim for them been made. Except for Part A and Part B of *Medicare*, the *Participant* or *covered dependent* must actually be covered by the other *programs*.

The *Plan* will exclude the benefits payable under any *program* in determining the above reduction if:

(1) that other *program* contains a provision which requires it to determine its benefits after the benefits of this *Plan*, and

(2) the rules set forth in the Order of Benefit Determination require this *Plan* to decide the benefits of this *Plan* before the other *program*.

When a reduction is made, each benefit that would have been payable in the absence of *this provision* will be reduced proportionately or in some other manner which the *Dental Claims Administrator* considers fair. The reduced amount will be charged against any benefit limit of this *Plan* that may apply.

Right to Receive and Release Necessary Information

A *claimant* will furnish any information necessary to implement *this provision*. The *Dental Claims Administrator* may release or obtain any information, with respect to the *claimant*, which it deems necessary This information may be released to or received from any insurer, other organization, or person. This may be done without the consent of or notice to the *claimant*. In so acting, the *Dental Claims Administrator* and *Plan* will be free from any liability

Facility of Payment

When payments which should have been made under this *Plan*, by the terms of *this provision*, have been made under any other *programs*, the *Dental Claims Administrator* has the right to pay to any organization making the other payments any amounts it determines are due to satisfy the intent of *this provision*. Any amount paid in good faith will release the *Plan* from further liability for that amount.

Recovery of Payment

If the *Dental Claims Administrator* pays more than the maximum amount required to satisfy the intent of *this provision* at that time, the *Dental Claims Administrator* has the right to recover the excess paid. Recovery may be made from any persons to, or for, or with respect to whom the payments were made, or from any other insurers or organizations. This includes the reasonable cash value of any benefits provided as a service.

ARTICLE EIGHT

CLAIM PROVISIONS

Filing of Claim

As a condition to the receipt of benefits, a *Participant* covered by the *Plan* who has a claim for benefits under the *Plan* must give written notice of such claim to the *Plan Administrator* on the application form specified by the *Plan Administrator* for that purpose. As a further condition to the receipt of benefits, a *Participant* must submit such notice of claim at any time before the end of 30 days after the date after any covered loss occurs, or within a reasonable time thereafter. The time limit for submitting a notice of claim is 90 days after the date of the loss. All applications for benefits under the *Plan* shall be submitted, with such information as the application shall require, to the *Dental Claims Administrator*. The application form must be completed by the *Employer*, *claimant* and the *dentist* providing *dental treatment* to the *claimant*. The *preferred provider* will send notice of all dental expenses incurred under the *preferred provider option.*

Time of Payment of Claim

After the *Dental Claims Administrator* has reviewed the claim form and obtained any other information deemed necessary to render a decision on the claim, the *Dental Claims Administrator* shall notify the *claimant* within 30 days after receipt of all data necessary to recommend the acceptance or denial of the *claimant*'s claim. Unless circumstances beyond the control of the *Plan* require an extension of time for processing the claim such recommendation shall be made within 30 days after receipt of the claim form. Such an extension of time may not exceed 15 additional days and notice of the extension shall be provided to the *claimant* prior to the termination of the initial 30 day period indicating the special circumstances requiring the extension and the date by which a final decision on the claim is expected.

To decide the *Plan's* liability, the *Dental Claims Administrator* may require additional information, including, but not limited to:

(a) itemized bills,

(b) proof of benefits from other sources,

(c) proof that the *claimant* has applied for all benefits from other sources, and that the *claimant* has furnished any proof required to get them,

(d) a complete dental charting indicating extractions, missing teeth, fillings, prosthesis, periodontal pocket depths, orthodontic relationship and the dates work was previously performed, and

(e) preoperative x-rays, study models, laboratory and/or hospital reports.

To Whom Payable

If the *Participant* or *covered dependent* assigns dental benefits to the provider of the dental *treatment*, any benefits payable under the *Plan* will be paid directly to the provider. Otherwise, any benefits payable under the *Plan* will be paid to the *Participant*. After the *Participant's* death, the *Dental Claims Administrator* has the option to pay any benefits payable under the *Plan* to the *Participant's* spouse; to the providers of the *treatment*; or to the *Participant's* estate.

Claim Denials

In the event any claim for benefits is denied, in whole or in part, the *Dental Claims Administrator* shall notify the *claimant* of such denial in writing and shall advise the *claimant* of the *Plan's* review and appeal procedure. The notice shall be written in a manner calculated to be understood by the *claimant* and shall contain:

(a) specific reasons for the denial;

(b) specific references to the *Plan* provisions on which the denial is based;

(c) a description of any information or material necessary for the *claimant* to perfect the claim;

(d) an explanation of why such information or material is necessary; and

(e) an explanation of the *Plan's* review and appeal procedure.

Discretion of Plan Administrator

The discretionary responsibility and authority to determine eligibility for participation in the *Plan* and to interpret *Plan* provisions and to determine whether a claim will be paid or denied rests solely with the *Plan Administrator*.

Appeal Procedure

If a claim is denied in whole or in part as recommended by the *Dental Claims Administrator* the following claims appeal procedure shall be observed:

(a) The *claimant*, or the *claimant's* duly authorized representative, may appeal the denial by submitting to the *Plan Administrator* or the *Dental Claims Administrator* a written request for review of the claim within 180 days after receiving written notice of such denial from the *Dental Claims Administrator* Failure by the *claimant* to submit a request for review within 180 days after receiving the denial of benefits shall constitute a waiver by the *claimant* of the right to appeal the decision. The *Plan Administrator* or the *Dental Claims Administrator* shall, upon the *claimant's* request, give the *claimant* an opportunity to review relevant documents, other than legally privileged documents, in preparing such request for review.

(b) The request for review must be in writing and shall be addressed as follows:

Assurant Employee Benefits
P.O. Box 2940
Clinton, IA 52733-2940

(c) The request for review shall set forth all of the grounds upon which it is based, all facts in support thereof and any other matters which the *claimant* deems pertinent. The *Plan Administrator* or the *Dental Claims Administrator* may require the *claimant* to submit, at the expense of the *claimant*, such additional facts, documents or other material as are necessary or advisable in conducting the review.

(d) The *Dental Claims Administrator* shall act upon each request for review within 60 days after the *Dental Claim Administrator* receives the request for review.

(e) In the event the *Plan Administrator* confirms the denial of the claim for benefits in whole or in part, written notice of the *Plan Administrator's* decision shall be given to the *claimant*. Such notice shall be written in a manner calculated to be understood by the *claimant* and shall contain the specific reasons for the denial.

Exhaustion of Administrative Remedies

No legal action for benefits under the *Plan* shall be brought unless and until the following has occurred:

(a) The *claimant* has submitted a proper written claim for benefits;

(b) The *claimant* has been notified by the *Dental Claims Administrator* that the claim is denied.

(c) The *claimant* has filed a written appeal with the *Plan Administrator* or the *Dental Claims Administrator* for review of the denied claim as recommended by the *Dental Claims Administrator*

(d) The *claimant* has been notified in writing of the *Plan Administrator's* decision to uphold the denial or the *Plan Administrator* has failed to take any action on the request for review within the time prescribed by the terms of the *Plan*.

Required Physician Examination

The *Dental Claims Administrator* may require the *claimant* to submit to a medical examination, to be paid for by the *Plan*, by a *doctor or dentist* selected by the *Dental Claims Administrator* upon submission of a claim for benefits under the *Plan*.

General Right to Receive and Release Necessary Information

Subject to state law requirements, the *Dental Claims Administrator* may, for the purpose of determining a *claimant's* qualification for an amount of benefits, and without the specific consent of any person, release to, or obtain from, any person, any information with respect to any person which the *Dental Claims Administrator* reasonably deems to be necessary for such purpose. Any *employee* shall furnish such information as the *Dental Claims Administrator* reasonably deems to be necessary to administer the *Plan*.

Overpayment

If a benefit is paid under the *Plan* and it is later shown that a lesser amount should have been paid, the *Plan* will be entitled to a refund of the excess amount from the provider or the *Participant*.

Subrogation Rights

In the event of any payments for benefits provided to the *Participant* or a *covered dependent* under the *Plan*, the *Plan* or *Plan Administrator* ("Subrogor"), as the case may be, to the extent of the *Plan's* payments, will be subrogated to all rights of recovery the *Participant* or a *covered dependent* has against any person or organization. The *Participant* or *covered dependent* will execute and deliver any instruments and papers as may be required and do whatever else is necessary to secure those rights to the Subrogor and will do nothing after loss to prejudice the Subrogor's rights. If the Subrogor is precluded from exercising the Subrogation Rights, the Subrogor may exercise the Right to Reimbursement.

Right to Reimbursement

If the *Participant* or a *covered dependent*: (a) seeks legal recourse (whether by suit, settlement, judgment or otherwise) against any person or organization; and (b) recovers payment, in whole or in part, from any such person or organization for the benefits previously paid under the *Plan*, then the *Participant* or *covered dependent* must reimburse the *Plan* for all payments made under the *Plan* for which reimbursement was received.

Any payments made prior to determination of work-related injury, will be reimbursed upon determination of such payment.

However, the reimbursement will not exceed: (a) the amount of the benefit payments made under the *Plan* for which payment is recovered from any person or organization; or (b) the amount recovered from any such person or organization as payment for the same covered dental expenses.

The *Participant* or *covered dependents* are not obligated by this provision to seek legal action against any person or organization for which benefits have been paid under the *Plan*.

ARTICLE NINE

CONTRIBUTIONS AND THE FUND

Actuarial Determinations and Methods

From time to time the *Plan Administrator* shall determine the amount of total contributions necessary to fund the liabilities and expenses of the *Plan* for the relevant time period. In establishing the liabilities and the contributions under the *Plan*, such methods and assumptions as will reasonably reflect the cost of the benefits will be utilized

Participating Employer Contributions

From time to time, the *Adopting Employer* and certain *Participating Employers*, as determined by the *Plan Administrator*, may contribute to the *Plan Administrator, Dental Claims Administrator* or any *Trust Fund* an amount determined by the *Plan Administrator* to be necessary to provide the benefits under the *Plan* determined by the application of accepted actuarial methods and assumptions. The method of funding shall be consistent with the *Plan* objectives. From time to time, the *Adopting Employer* and certain *Participating Employers*, as determined by the *Plan Administrator*, shall contribute to the *Plan Administrator, Dental Claims Administrator* or any *Trust Fund* an amount determined by the *Plan Administrator* to be necessary to provide for the expenses necessarily incurred to establish and maintain the *Plan*.

Employee Contributions

From time to time, each *Participant* of certain *Employers* shall contribute to any *Trust Fund* such amounts as may be required under the *Plan* in accordance with a uniform, nondiscriminatory procedure established by the *Plan Administrator*

Trust Fund

As part of the *Plan*, a *Trust Fund* may be created by the *Adopting Employer* under which the *Trustee* or *Trustees* receives any designated contributions of *Participants* and *Employers* and holds, invests and distributes the *Fund* in accordance with the terms and provisions thereof. All expenses incident to administering the *Trust* shall be paid out of the *Fund*.

Source of Benefits

If a *Trust Fund* is created under the above section, all benefits under the *Plan* shall be provided solely from the *Fund*, and neither the *Plan Administrator*, *Plan Sponsor*, *Adopting Employer*, or the *Participating Employers* or either their officers, directors or stockholders shall have any liability or responsibility therefore. Neither the *Plan Administrator, Plan Sponsor, Adopting Employer*, nor the *Participating Employers*, shall be liable in any manner should the *Fund* be insufficient to provide for the payment of any benefit under the *Plan*.

ARTICLE TEN

ADMINISTRATION

Plan Sponsor

The *Plan Sponsor* is identified in Article One: ERISA Information.

Plan Administrator

The *Plan Administrator* is identified in Article One: ERISA Information.

Powers, Duties and Responsibilities of Plan Administrator

The primary responsibility of the *Plan Administrator* is to administer the *Plan* for the exclusive benefit of the *Participants* and their *covered dependents*, subject to the specific terms of the *Plan*. The *Plan Administrator* shall administer the *Plan* in accordance with its terms and shall have the power to determine all questions arising in connection with the administration, interpretation, and application of the *Plan*. Any such determination by the *Plan Administrator* may correct any defect, supply any information, or reconcile any inconsistency in such manner and to such extent as shall be deemed necessary or advisable to carry out the purpose of this *Plan*; provided, however, that any interpretation or construction shall be done in a nondiscriminatory manner and shall be consistent with the intent that the *Plan* shall comply with the terms of *ERISA* and all regulations issued pursuant thereto. The *Plan Administrator* shall have all discretionary authority to accomplish his duties under this *Plan*.

The *Plan Administrator* shall be charged with the duties of the general administration of the *Plan*, including, but not limited to, the following:

(1) to determine all questions relating to the eligibility of *employees* to participate or continue participation hereunder;

(2) to maintain all necessary records for the administration of the *Plan*;

(3) to interpret the provisions of the *Plan* and to make such rules for regulation of the *Plan* as are consistent with hereof;

(4) to determine the size and type of any contract to be purchased from any insurer, and to designate the insurer from which such contract shall be purchased;

(5) to direct the computation and certification from time to time of the sums of money necessary or desirable to be contributed to any *Trust Fund*;

(6) to assist any *Participant* regarding his rights, benefits or elections available under the *Plan*;

(7) to communicate to *employees*, *Participants* and their *covered dependents* a summary plan description outlining the provisions of the *Plan* as required under Title I of *ERISA*;

(8) to review and decide appeals by claimants from the denial of benefits as recommended by the *Dental Claims Administrator*;

(9) to appoint or employ one or more persons to assist in the administration of the *Plan* or to render advice with regard to any of its responsibilities under the *Plan*;

(10) to prescribe procedures to be followed by *employees* making claims for benefits; and

(11) to request from *Employers*, *Participants* and *employees* such information as shall be necessary for proper administration of the *Plan*.

Reliance Upon Information

In making decisions under the *Plan*, the *Plan Administrator* shall be entitled to rely upon information furnished by an *employee*, *Employers*, *Participants*, *Dental Claims Administrator*, counsel, *doctor* or *dentist*

Records and Reports

The *Plan Administrator* shall keep a record of all actions taken and shall keep all other books of account, record, and other data that may be necessary for proper administration of the *Plan* and shall be responsible for supplying all information and reports to the Internal Revenue Service, Department of Labor, *Participant*, and others as required by law.

Information From Participating Employers

To enable the *Plan Administrator* to perform its functions, *Employers* shall supply full and timely information to the *Plan Administrator* on all matters as the *Plan Administrator* may require. The *Plan Administrator* may rely upon such information as is supplied by *Employers* and shall have no duty or responsibility to verify such information.

ARTICLE ELEVEN

AMENDMENT AND TERMINATION OF THE PLAN

Amendment and Termination of the Plan

The *Adopting Employer* intends for the *Plan* to continue indefinitely; however, the *Adopting Employer* reserves the right to alter, amend or terminate this *Plan* at any time, for any reason, in whole or in part, provided that no amendment shall authorize or permit any part of any *Trust Fund* to be used or diverted to any purpose other than to the exclusive benefit of the *Participants*. Notwithstanding the foregoing, this *Plan* may be amended at any time to conform its provisions to the requirements of *ERISA*, the Internal Revenue Code, Treasury Regulations or rulings there under.

Final Distribution Upon Plan Termination

As provided in the section above, the *Adopting Employer* shall have the right to terminate this *Plan* at any time for any reason. Upon a complete termination, no part of any *Trust Fund* shall be used or diverted to any purpose other than to the exclusive benefit of the *Participants*, unless otherwise permitted by law.

ARTICLE TWELVE

MISCELLANEOUS

Gender and Number

Wherever any words are used herein in the masculine, feminine or neuter gender, they shall be construed as though they were also used in another gender in all cases where they would so apply, and whenever any words are used herein in the singular or plural form, they shall be construed as though they were also used in the other form in all cases where they would so apply.

Uniformity

All provisions of this *Plan* shall be interpreted and applied in a uniform, nondiscriminatory manner

No Guaranty of Employment

The *Plan* does not constitute a contract between an *Employer* and any *employee* and is not a consideration for, or an inducement for, the employment of any *employee* by an *Employer* Nothing contained in the *Plan* shall be deemed to give any *employee* the right to be retained in the services of an *Employer* or to interfere with the *Employer's* right to terminate the employment of an *employee* at any time without regard to the effect the termination may have on such *employee's* participation in the *Plan*.

Headings Not to Control

Headings and titles within the *Plan* are for convenience only and are not to be read as part of the text of the *Plan*.

Separability of Plan Provisions

If any provisions of the *Plan* are declared invalid or not enforceable for any reason, such provisions will not affect the remaining terms and conditions which shall be construed and enforced thereafter as if such invalid or unenforceable provisions had not been inserted.

Applicable Law

The validity and effect of the *Plan* and the rights and obligations of all persons affected thereby, are to be construed and determined in accordance with applicable federal law, and to the extent that federal law is inapplicable, under the laws of the State of MS.

Entire Plan

This document is a complete statement of the *Plan* and as of the effective date listed on the Execution Page supersedes all prior plans, proposals, representations, promises and inducements, written or oral, relating to its subject matter. The *Employers* shall not be bound by or liable to any person for any representation, promise or inducement made by any person which is not embodied in this document or in any authorized written amendment to the *Plan*.

STATEMENT OF ERISA RIGHTS

As a *Participant* in (name of plan) you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all *Plan Participants* shall be entitled to:

Receive Information About Your Plan and Benefits

Examine, without charge, at the *Plan Administrator's* office and at other specified locations, such as worksites and union halls, all documents governing the *Plan*, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the *Plan* with the U.S. Department of Labor and available at the Public Disclosure Room of the Pension and Welfare Benefit Administration. Obtain, upon written request to the *Plan Administrator*, copies of documents governing the operation of the *Plan*, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The administrator may make a reasonable charge for the copies.

Receive a summary of the *Plan*'s annual financial report. The *Plan Administrator* is required by law to furnish each *Participant* with a copy of this summary annual report.

Continue Group Health Plan Coverage

Continue health care coverage for yourself, spouse or dependents if there is a loss of coverage under the *Plan* as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this summary plan description and the documents governing the *Plan* on the rules governing your COBRA continuation coverage rights.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for *Plan Participant*s ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your *Plan*, called "fiduciaries" of the *Plan*, have a duty to do so prudently and in the interest of you and other *Plan Participant*s and beneficiaries. No one, including your *Employer*, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

Enforce Your Rights

If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of *Plan* documents or the latest annual report from the *Plan* and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the *Plan Administrator* to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. In addition, if you disagree with the *Plan*'s decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in Federal court. If it should happen that *Plan* fiduciaries misuse the *Plan*'s money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions

If you have any questions about your *Plan*, you should contact the *Plan Administrator* If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the *Plan Administrator*, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W.,

Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

NOTICE OF COBRA CONTINUATION COVERAGE RIGHTS

Introduction

This notice contains important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the *Plan*. The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you and to other members of your family who are covered under the *Plan* when you would otherwise lose your group dental coverage. This notice generally explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it. This notice gives only a summary of your COBRA continuation coverage rights.

The *Plan Administrator* is City of Gulfport PO Box 1780, Gulfport, MS 39501 The *Plan Administrator* is responsible for administering COBRA continuation coverage.

COBRA Continuation Coverage

COBRA continuation coverage is a continuation of the *Plan* coverage when coverage would otherwise end because of a life event known as a "qualifying event." Specific qualifying events are listed later in this notice. COBRA continuation coverage must be offered to each person who is a "qualified beneficiary " A qualified beneficiary is someone who will lose coverage under the *Plan* because of a qualifying event. Depending on the type of qualifying event, e*mployee*s, spouses of e*mployee*s, and dependent children of e*mployee*s may be qualified beneficiaries. Under the *Plan*, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you are an e*mployee*, you will become a qualified beneficiary if you will lose your coverage under the *Plan* because either one of the following qualifying events happens:

(1) Your hours of employment are reduced, or

(2) Your employment ends for any reason other than your gross misconduct.

Your dependent spouse will become a qualified beneficiary if your dependent spouse loses coverage under the *Plan* because any of the following qualifying events happens:

(1) You die;

(2) Your hours of employment are reduced;

(3) Your employment ends for any reason other than gross misconduct; or

(4) You become divorced or legally separated from your spouse.

Your dependent children will become qualified beneficiaries if they will lose coverage under the *Plan* because any of the following qualifying events happens:

(1) You die;

(2) Your hours of employment are reduced;

(3) Your employment ends for any reason other than gross misconduct;

(4) You become divorced or legally separated, or

(5) The child stops being eligible for coverage under the *Plan* as a "dependent child."

Sometimes, filing a proceeding in bankruptcy under title 11 of the United States Code can be a qualifying event. If a proceeding in bankruptcy is filed with respect to City of Gulfport, and that bankruptcy results in the loss of coverage of any retired *employee* covered under the *Plan*, the retired *employee* is a qualified beneficiary with respect to the bankruptcy The retired *employee*'s spouse, surviving spouse, and dependent children will also be qualified beneficiaries if bankruptcy results in the loss of their coverage under the *Plan*.

The *Plan* will offer COBRA continuation coverage to qualified beneficiaries only after the *Plan Administrator* has been notified that a qualifying event has occurred. When the qualifying event is the end of employment or reduction of hours of employment, death of the *employee*, the *Employer* must notify the *Plan Administrator* of the qualifying event within 30 days following the date coverage ends

For the other qualifying events (divorce or legal separation of the *employee* and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the *Plan Administrator* The *Plan* requires you to notify the *Plan Administrator* within 60 days after the qualifying event occurs. You must send this notice to: City of Gulfport.

Once the *Plan Administrator* receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. For each qualified beneficiary who elects COBRA continuation coverage, COBRA continuation coverage will begin on the date that Plan coverage would otherwise have been lost.

COBRA continuation coverage is a temporary continuation of coverage. When the qualifying event is the death of the *employee*, your divorce or legal separation, or a dependent child losing eligibility as a dependent child, COBRA continuation coverage lasts for up to 36 months.

When the qualifying event is the end of your employment or reduction of your hours of employment, COBRA continuation coverage lasts for up to 18 months. There are two ways in which this 18-month period of COBRA continuation coverage can be extended.

Disability Extension of 18-month Period of Continuation Coverage

If you or anyone in your family covered under the *Plan* is determined by the Social Security Administration to be disabled at any time during the first 60 days of COBRA continuation coverage and you notify the *Plan Administrator* in a timely fashion, you and your entire family can receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months. This notice should be sent to City of Gulfport.

Second Qualifying Event Extension of 18-month Period of Continuation Coverage

If your family experiences another qualifying event while receiving COBRA continuation coverage, your spouse and dependent children can receive additional months of COBRA continuation coverage, up to a maximum of 36 months. This extension is available to your spouse and dependent children if you die or you get divorced or legally

separated. The extension is also available to a dependent child when that child stops being eligible under the *Plan* as a dependent child. In all of these cases, you must make sure that the *Plan Administrator* is notified of the second qualifying event within 60 days of the second qualifying. This notice must be sent to: City of Gulfport.

If You Have Questions

If you have questions about your COBRA continuation coverage, you should contact City of Gulfport or you may contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA). Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website at www.dol.gov/ebsa.

Keep Your Plan Informed of Address Changes

In order to protect your family's rights, you should keep the *Plan Administrator* informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the *Plan Administrator*

QUALIFIED MEDICAL CHILD SUPPORT ORDER (QMCSO)

A Qualified Medical Child Support Order (QMCSO) is an order from a court or administrative agency that enforces the medical child support obligations of a non-custodial parent. A National Medical Support Notice (NMSN) issued by a state agency if properly completed is accepted as a QMCSO.

To qualify as a QMCSO the order must clearly specify certain information as follows:

(a) The name and address of the *Participant* (the e*mployee*) and the name and address of the alternate recipient (any child of the *Participant* who is recognized under the Order as having a right to enrollment) or the alternate recipient's designee.
(b) Type of coverage to be provided.
(c) Period to which the Order applies.

If the Order requires any type or form of benefit or any option not otherwise provided under the Plan, then such Order shall not qualify as a QMCSO. If the Order is deemed to meet the requirements to qualify as a QMCSO and the *Participant* has waived coverage or is enrolled in a different level of coverage (for example single coverage) the Plan Administrator is required to enroll the *Participant* and qualified alternate recipient in the appropriate Plan; applicable premiums associated with the level of coverage will be withheld from the *Participant*'s paycheck.

A complete description of what qualifies as a QMSCO along with the procedures that must be followed by the Plan Administrator and the submitting entity is available from your Plan Administrator Orders being submitted for consideration should be directed to the Plan Administrator

COMPLIANCE WITH THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996

Use and Disclosure of Protected Health Information

Notwithstanding any provision in this *Plan* to the contrary, the *Plan* will use and disclose Protected Health Information (PHI) only to the extent of and in accordance with the uses and disclosures permitted by the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and implementing regulations (45 C.F.R. Part 160-164) Specifically, the *Plan* will use and disclose PHI for purposes related to dental care treatment, payment for dental care, and/or dental care operations.

Special Definitions

Individually Identifiable Health Information: health information that is created or received by the *Plan* or the *Employer* which relates to the past, present or future physical or mental health or condition of an individual or the past, present or future provision of health/dental care to an individual, and which identifies (or provides a reasonable basis for identifying) such individual.

Plan Administration Functions: administration of functions performed by the *Employer* on behalf of the *Plan* and excludes functions performed by the *Employer* in connection with any other benefit or benefit plan of the *Employer*

Protected Health Information: Individually Identifiable Health Information except as specifically excluded from this definition, that is (i) transmitted by electronic media; (ii) maintained in any medium described in the definition of electronic media at 45 C.F.R. 162.103; or (iii) transmitted or maintained in any other form or medium. Protected Health Information excludes Individually Identifiable Health Information in (i) education records covered by the Family Educational Rights and Privacy Act, as amended, 20 U.S.C. 1232g; (ii) records described at 20 U.S.C. 1232g(a)(4)(B)(iv); and (iii) employment records held by a covered entity in its role as *Employer*

Treatment: the provision, coordination, or management of dental care and related services by one or more dental care providers, including the coordination or management of dental care by a dental provider with a third party; consultation between dental care providers relating to a patient; or the referral of a patient for health or dental care from one dental care provider to another.

Certification by the Employer

Neither the *Plan*, nor any dental insurance issuer to business associate servicing the *Plan* shall disclose a *Participant*'s PHI to the *Employer* unless the *Employer* certifies that the *Plan* has been amended to incorporate HIPAA's privacy provisions and agrees to abide by such privacy provisions.

Employer Covenants

The *Employer* agrees to:

(a) not use or further disclose PHI other than as permitted or required by the *Plan* document or as required by law;
(b) ensure that any agents, including subcontractors, to whom the *Employer* provides PHI received from the *Plan* agree to the same restrictions and conditions that apply to the *Employer* with respect to such PHI;
(c) not use or disclose PHI for employment-related actions and decisions unless authorized by an individual;
(d) not use or disclose PHI in connection with any other benefit or employee benefit plan of the *Employer* unless authorized by the individual with respect to whom the PHI relates;
(e) report to the *Plan* any use or disclosure of PHI of which it becomes aware that is not permitted under the *Plan*'s privacy policies and procedures or the HIPAA privacy regulations;
(f) make PHI available to an individual in accordance with HIPAA's access requirements;

(g) make PHI available for amendment by an individual and incorporate any amendments to PHI in accordance with HIPAA,
(h) make available the information required to provide an accounting of disclosures;
(i) make internal practices, books and records relating to the use and disclosure of PHI received from the *Plan* available to the HHS Secretary for the purposes of determining the *Plan*'s compliance with HIPAA, and
(j) if feasible, return or destroy all PHI received from the *Plan* that the *Employer* still maintains in any form, and retain no copies of such PHI when no longer needed for the purpose for which disclosure was made (or if return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction infeasible).

Adequate Separation Between the Plan and the Employer Must Be Maintained

In accordance with HIPAA, only the following e*mployee*s and classes of e*mployee*s of the *Employer* may be given access to PHI:

(a) The Privacy Officer;
(b) Staff designated by the Privacy Officer.

Limitations of Protected Health Information Access and Disclosure

The e*mployee*s and class of e*mployee*s identified in the above paragraph may only have access to and use and disclose PHI for *Plan Administration Functions* that the *Employer* performs for the *Plan*.

Noncompliance Mechanism

The e*mployee*s or class of e*mployee*s identified above will be subject to disciplinary action and sanctions, including termination of employment or affiliation with the *Employer*, for any use or disclosure of PHI and breach or violation of or noncompliance with the provisions of this section. The *Employer* will promptly report such breach, violation or noncompliance to the *Plan* as required above and will cooperate with the *Plan* to correct the breach, violation or noncompliance, to impose appropriate disciplinary action or sanctions on each e*mployee* or other workforce member causing the breach, violation or noncompliance on any person, the privacy of whose PHI may have been compromised by the breach, violation or noncompliance.